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ABSTRACT

During a symposium on adolescent pregnancy, medical and education personnel presented an overview of the problem and its causes, a description of solutions currently in practice throughout the country, analysis of the state of research in the field of prevention, and a look at the government's role. Addressed in this transcipt of the symposium are such areas as: trends in pregnancy among adolescents; motivational influences; prevention strategies; program implementation; collaborative approaches; school-based clinics; parent child relationship; physician responsibility; school dropout complications; the role of religion; and future directions. (CB)

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Preventing Adolescent Pregnancy:

A Symposium for Journalists

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Introduction

Preventing Adolescent Pregnancy:

A Symposium for Journalists

More than a million adolescents get pregnant every year in this country. When a teenager has a baby, the chances are high that she will end up as a single, unemployed mother on welfare. Her new family is likely to be a burden that will greatly diminish any options or dreams she may have had. Too, she and her new baby may well become a burden to our society. Implications for the father and child are equally ominous.

Little, if any, media attention has focused on specific initiatives to prevent adolescent pregnancy, nor has the press attempted to explain why a national effort has not been undertaken. As a result, many Americans remain ignorant to the problem and its causes, as well as to the possible steps to prevention and resolution.

On May 14, 1986, the Scientists' Institute for Public Information (SIPI) presented a symposium for journalists to discuss what has and has not been done to prevent adolescent pregnancy. This is the transcript of that presentation.

"Preventing Adolescent Pregnancy" is the first in a series of discussions and briefings of SIPI's Child Health and Development Program. SIPI is also expanding its resource base so that its Media Resource Service — a tollfree hotline for journalists who need to speak to experts for background information or quotes — can refer journalists to professionals involved in a wide variety of children's issues. In this way we hope to improve and increase media coverage in this field. We gratefully acknowledge the contributions of the American Can Company Foundation, The Carnegie Corporation of New York, The Commonwealth Fund, The Conrad N. Hilton Foundation, and The Robert Wood Johnson Foundation for making this symposium possible.

Please note that since this is a transcript of a discussion, it does not read like an article or fully-edited text. It contains the original phraseology and syntax used by the speakers.

During the symposium, experts presented an overview of the problem and its causes, a description of solutions currently in practice throughout the country, an analysis of the state of research in the field of prevention, and a look at the government's role. Then the floor was opened up to journalists for questions, with the goal of increasing public awareness and understanding of the causes, effects and issues surrounding the problem of adolescent pregnancy.

Preventing Adolescent Pregnancy: A Symposium for Journalists

Deborah Walter: Good Morning. I'd like to thank you for coming here and joining us this morning. I'm Deborah Walter, Director of the Child Health and Development Program from the Scientists' Institute for Public Information (SIPI). Today is the first in what we hope will be a series of briefings on children's issues. I'd like to thank the speakers for donating their time and coming from around the country to be with us. And I'd very much like to thank The American Can Company Foundation, The Carnegie Corporation of New York, The Commonwealth Fund, The Conrad N. Hilton Foundation, and The Robert Wood Johnson Foundation for making today possible. Further information about adolescent pregnancy and other children's issues is always available through SIPI's Media Resource Service.

We are fortunate to have Dr. Jerome Goldsmith moderate today's discussion. Dr. Goldsmith is Executive Vice Chair of the Jewish Board of Family and Children's Services, the nation's largest provider of mental health and social services. He is also Chairman of our Advisory Committee on Child Health and Development. Thank you for being with us.

Dr. Goldsmith: Let me add my good morning and thank you for being here. One of the things that I want to do as a good moderator and chairman is to keep my mouth shut and to go to the subject which you're here for. So let me, just in terms of housekeeping, say to you that each speaker will talk for about ten minutes to be followed when everyone is finished with your questions.

Our first speaker is Karen Pittman, Director of the Adolescent Pregnancy Prevention Clearinghouse of the Children's Defense Fund. She will present an overview of the problem as well as various approaches to solutions now in place across the country.

Trends in Pregnancy Among Adolescents

Karen N. Pittman: I'll try to stay on the short side of ten minutes. I'm sure you're here today because you have a good general sense of what the problem is.

If you've read through your packets of background information, then you have some idea of the numbers of young people affected by this issue. So I'm not going to spend a lot of time talking about that. What I'd like to do very quickly, so that we can move on to the other speakers, is just briefly lay out for you a framework for thinking about the problem. I suggest that we look not just at numbers but at trends in beginning to think through the problem.

I'm sure you know that there are over a million teen pregnancies each year to

young women under the age of twenty. About five hundred thousand of those result in births. The number of births has been going down — that is a trend we should all keep in mind. The numerical problem is going away slowly if you define the problem as teenage parenthood, but the problem has other ramifications.

I think that it's important to begin by saying, first of all, that births have been going down. However, one of the reasons for alarm is that while births have been going down, the proportion of those births that are to young women who are single parents at the time of these births has been going up. That number has been going up steadily. It's been going up faster for white teens than for black teens. This is basically cause for some alarm because of the implications of poverty in single parenthood.

I'd like to add a fact that is picked up less frequently. Certainly there have been increases in the number of teenage parents who are raising their children as single parents, and this has clear ties to poverty. Yet, we've had another change over the past five years that should also be kept in mind. Because teenagers and young adults disproportionately take minimum wage jobs and, as you all know, unemployment among teenagers and especially among minority teenagers is at especially high levels — even if we have your "typical two-parent young family" — we're still looking at high levels of poverty.

This is something that I think is very important to bring out. The problems of adolescent parenthood, while exacerbated by the fact that we have increasing numbers of single parents, are not solely tied to the numbers of single parenthood. A young person who's working fifty weeks a year and forty hours a week in a minimum wage job is still earning below-poverty wages. And about sixty-three percent of sixteen to nineteen year olds, if they are employed, are in jobs that keep them below poverty level even if they are working full time, full year. We have to keep this in mind when we are talking about why adolescent parenthood is a problem.

In many ways adolescence now stretches well into the the twenties. For teenagers attempting to begin the responsibilites of parenthood, either before completing high school or just with a high school education, we are finding that they are more and more apt to be at an economic disadvantage. That's certainly true if they are single parents, but it's also true if we are looking at a two-parent family with a child.

As we begin to frame the issue let us also consider the international data. Although birth rates and the absolute number of births to teens have been going down in the United States over the past decade or decade and a half, the numbers of pregnancies, births, and abortions to teens in the U.S. are at levels that are very much higher than those found in European countries and in Canada. England, France, and Wales all have rates that are about half those found in the U.S. according to a study carried out by the Alan Guttmacher Institute about ten months ago. That's very important because, when you think about it, the policy implications of those findings are quite clear.

We have in America roughly comparable rates, as best they could estimate, of sexual activity among our adolescents, but we end up with many more pregnancies and therefore many more births and abortions. Why is that? While

they didn't find any single explanation for this difference in those other countries, they did find a general acknowledgement that what is not desirable is adolescent pregnancy.

This contrasts the focus on whether adolescent sexual activity is desirable or not. Where you find earlier and more comprehensive sex education, you find better access to contraceptive services for teens. These two elements, in Joy Dryfoos' words, "give teens the capacity to delay parenthood." When we give them information, when we give them services, when we approach the issues through the media, and when adults feel comfortable with the issue, we get across very clearly the idea that adolescent pregnancy is something that is not desirable. If you are sexually active, you should be responsibly sexually active.

That message obviously gets across much better in other countries than it does in the United States, where we know that the average young woman — and we clearly know more about the contraceptive practices of young women than of young men — takes nine months to a year to show up at a family planning clinic once she's become sexually active. Half of the unintended pregnancies that occur to teens occur within the first six months of sexual activity.

If we could somehow prepare the climate, pull the services together, and get the information out there, we can help teens more easily think about the fact that they are sexually active and take responsiblity for their sexual activity. In these ways we could bring our rates much closer to those that are evidenced in other countries. We must reduce that gap that we find between the initiation of sexual activity and the visit to a clinic to get contraceptive counseling and services.

Motivational Influences

When we are talking about strategies for addressing this problem as it relates to other countries, we must also look at the variations of data within the U.S. The data that we have concerning birth rates collected in the U.S. is collected according to race, black and white. Since we look at data along racial lines as opposed to income lines, we're forced to then make some assumptions based on other studies on supplemental factors. At least part of what we are looking at are income differences. But the rates that we see, across the Atlantic as well as with the U.S., pregnancies, births, and abortions are higher for minority teens than those that we find for white teens.

The question becomes: Is it the same phenomenon? Do we have a population in the U. S. for which access to information is even more restricted, or do we have to turn to some other explanation for the variation in pregnancy and birth rates according to race? There is a growing consensus, I believe, that we must change gears and think about some slightly different things.

Yes, we may have additional problems in creating access to information and building the capacity to delay parenthood among low income and minority teens, but we also have some motivational problems. By motivation I'm not talking about laziness. I'm talking about reasons for delaying parenthood. Clearly, once you are sexually active the natural end point, if no conscious

decisions are made, is unwed parenthood. The question is what can influence teens to begin to make those decisions, especially in a country where the climate for making those decisions is not great and once those decisions are made you often have to face hassles in order to follow through on them.

Given that we're not making it easy for teens to decide, "Aha, I'm sexually active, I'm really planning to be sexually active, I need to go get contraceptive services", what is going to motivate a teen to think about those decisions and to go out to seek information and services? And the answer to that, I believe, is the more that teens — male or female — feel they have to lose if they become pregnant and a parent too soon, the more likely it is that they are going to feel compelled to think and make decisions about contraceptive use, about abortion if they become pregnant, about adoption, and about marriage. Those decisions will then be made in the context of weighing the pros and cons.

We're finding from analyses of large data sets, such as the High School and Beyond data and the National Longitudinal Survey, that there is a definite relationship between feeling there is something in your future that you are going to be giving up or risking through unwanted pregnancy or parenthood and making these decisions and efforts to conciously avoid parenthood. Teens who are academically behind in school, data shows, are about three times as likely to become unwed parents as teens who are on grade level. The same sort of gaps seem to exist for low income teens vs. advantaged teens.

What this seems to suggest is that we need the U.S. to develop strategies that give all of our teens the capacity to delay parenthood and that very consciously evaluate whether all of our teens have very solid and compelling reasons for delaying parenthood. When we are dealing with teens who don't have those reasons, either because, one, over the course of their childhood and adolescence they have not developed the skills that are going to allow them to go into post-secondary education, to move into filling jobs or to gain employment; or two, they do not have the opportunities for a variety of reasons to do those things, or cannot envision those opportunites for themselves, then we must put together strategies that embrace both the capacity-building and motivation needs of teens. They must come together.

We need to think through a triage system of how we address adolescent pregnancy with the understanding that if the reason isn't there, the capacity-building pieces that we put in are clearly going to have an effect but not a maximum effect. Both of those pieces have to be there.

Joy Dryfoos is going talk to you about some of the research that's been done. You have in your packets some information I've completed on a variety of programs across the country that show, while we're far from having wonderful or conclusive evaluation data on almost any of them, they are attempting to put these pieces together. Some specifically address the capacity-building through education, through contraceptive services. These are the sexuality-specific programs. I've also included examples of broader basic support programs that attempt to pick up the sexuality-specific pieces and place them in a larger context.

I will say in closing that the growing popularity of the school-based clinic is in large part due to the fact that it's really a juxtaposition of these two things.

You are putting sexuality — specific information and services into a general support system for teens, in this case general health care. One of the things that makes that approach so exciting is that while sexuality-specific information plugs in very naturally to health care for teens, it also plugs in quite well to basic education services for teens, career exploration services and recreation services, quite a variety of things. Think about what kids need to become self sufficent adults. They need basic health care. They need education. They need employment opportunites and experience. They need non-academic opportunites for developing self-esteem and experiencing self-successs. They need role models and an understanding of their communities. Wherever there are programs that interact with teens in those basic ways, we can juxtapose and fit in these capacity-building pieces and come up with, I think, a much more effective system of dealing with adolescent pregnancy in the U.S.

Jerome Goldsmith: While we are on the subject of preventing adolescent pregnancy, Karen Pittman reminds me of the recent findings we have which point to our greatest failing in this system. One of the members of our staff sits on the fatality review committee here in New York City, where the deaths of infants and young children are reviewed. It is incredible. They are all tragic deaths, but almost all of them are the children of pregnant teenagers — young girls who's own life experience have been a life history and in the order of so many of the things that you've mentioned, culminates in this tragedy.

Our next speaker is Joy Dryfoos, an independent researcher who has studied adolescents-at-risk for more than twenty years. Currently she is funded by the Carnegie Corporation to develop a strategy for reaching that population. Today she will analyze the state of research for preventing adolescent pregnancy and what we know about what works.

Research: "What We Know"

Joy Dryfoos: Thank you. A panel on adolescent pregnancy, convened by the National Academy of Sciences, has just concluded a two year review of all the research on the subject, and I can tell you that there is literally tons of it. When you get access to the report, if you're motivated enough to read all three volumes, you'll see what I mean.

But what is in very short supply in that report is program evaluation research. The discussion on the panel focused on difficulties with methodology, practical problems and ethical problems that inhibited researchers and affected the quality and reliability of research. They expressed concern about the lack of resources for evaluation and, in fact, in the short laundry list of the state-of-the-art that follows here, there's not a single government dollar. The Center for Population Research National Institute of Child Health and Human Development, which has supported population research, has been very generous about items like sample surveys (such as the Johns Hopkins survey on adolescent sexuality, contraception and pregnancy) and some of the research that Karen's cited. However, program evaluation really has not been funded

because people, even social scientists and certainly behavioral scientists, are not very interested in programs. And, even if the money were there, do we have the experts who know how to evaluate research? Yet the question that always comes up and that you people are always asking is, "What works?"

The National Academy of Sciences panel, which was made up of "leading experts, "was concerned after its review that the accumulated program documentation and growing body of evaluation could provide enough insights into how well various approaches work to draw some conclusion. In other words, while there is insufficent science,there is a great deal of common sense and an awful lot of experience. That's certainly the way I see it and I've been working in this area for years.

When you are trying to evaluate various studies, it's important to understand what the real research problem is — we're trying to find out what prevents *pregnancy*. In research, we have to link the program intervention, whatever it is, to the ultimate outcome, which is the prevention of pregnancy. The conditions for doing this are, first of all, having experimental and control groups and, having them over a long enough period of time for the pregnancy not to take place. We also have to be able to measure pregnancy rates at different points in time. But pregnancy rates include abortions, and, in fact, without the knowledge of whether or not young women are getting abortions, we really can't say whether or not a program is preventing pregnancy. And since abortions are usually underreported in personal interviews, pregnancy rates are difficult to measure.

We can, however, obtain reliable data on birth rates over time. But that information is also difficult to get because that you have to follow clients around for several years after they've been to a particular program. Or, finally, we come down to clinic visit records, school records, and the simplest kind of measurement, such as pre- and post-tests of whether knowledge was gained or whether reported behavior was different.

I've been looking at all the other types of prevention literature lately, especially in the area of substance abuse. What I'm finding is that almost all the prevention literature on drugs and alcohol is *self- reported behavior*. We don't know whether any of Nancy Reagan's favorite programs really prevent anything or whether the participants are trying to please the people who ask them the questions by reporting decreases in smoking and/or drinking.

Nevertheless, getting back to teen pregnancy, because it is so difficult to measure that ultimate outcome — the prevention of pregnancy — we have to turn to a number of *surrogate* measures. The best one is *birth rates* if they are available. Otherwise, we must begin to look at "capacity-building" preventions, and the most important one is *using contraception effectively*. It is very well-documented that if a young person uses pills continuously she will not get pregnant. A step from that is using any kind of contraception and attending a clinic, in other words, *clinic* utilization. Further away from that, is *knowing the facts of life*. Connected to that is being able to *make decisions* if you know the facts of life. Finally moving into the whole area which I call "Life Options": *having a reason to prevent pregnancy* and finally, an indirect measurement of

an attribute which ultimately may affect somebody's being able to be a sexually responsible young person, *school achievement*. I personally feel, from my own review of research, that this is very fundamental to all the issues that we might be talking about regarding young people today.

It's almost impossible to go through a state-of-the-art about what works in such a short review; I will just cite some of the highlights from the findings.

Strategies of Prevention

Starting with school-based clinics, you might be interested to know that there are now about sixty of them. Exemplary multi-service clinics that include family planning in the roster of services may be found in St. Paul, Dallas, Kansas City, Jackson, Mississippi, and in almost every major urban area and a few rural school systems. In some of the school-based clinics, they were able to prove that birth rates decreased, and they have very good information on high levels of contraceptive utilization and continuation. Other results of clinic research include better general health practices and great popularity among the students and their families.

There are other variants of schools with capacity-building programs, most notably one that took place in Baltimore, where clinic personnel, social workers, and nurse practitioners went into schools, provided education and counseling and referred students to a nearby clinic. In that clinic students received contraceptive services. Carefully documented research by Laurie Zabin has shown lower pregnancy rates and a delay in sexual debut among the experimental group at the same time that pregnancy rates were increasing in the control group. What's interesting in this study is that Junior High School boys used the clinic to a very high degree, increasing their utilization more than girls or older boys.

Another kind of school-based activity was initiated by the Junior League in St. Louis and is now being replicated in many cities. This program, Teen Outreach, does not have a medical component but does have group discussion after school and a community service component consisting of weekly volunteer service. That program has shown lower birth rates and lower school drop-out rates.

Another area that is sometimes omitted in discussions like this is family planning clinics. Actually, family planning clinics should be first in order, because they reach more than a million young people every year. There are some four to five thousand clinics; many of them are supported by government funds('Title X'). They certainly enhance contraceptive utilization; of the million and a half teenagers who go to them, at least seventy percent are given contraceptive pills.

There's a great deal of research on what enhances that utilization. If a clinic is convenient and confidential and there is not very much "hassle," young people will go to it. More recently there's been a great interest in contraceptive continuation. It has been documented that half the adolescent kids who go to clinics never make a return visit. So there's been much more effort given to

keeping them in the clinic services. One study has come up with the finding that the element that was the most important was what was called "authoritative guidance." This means a much more directive appproach to young people. Rather than saying, " It is up to you to make this decision. We're going to have this cafeteria of services, and you just use your own best judgment."clinic personnel have changed their message to, "You think you want to use the pill. This is what you have to do to use it."

This research has led to a new and interesting approach called "Contract Counseling," a method used in other kinds of medical compliance where the client or the patient signs a contract. One small study shows that young women who both signed a contract and were offered incentives in the way of movie passes and records were much more likely to come back to the clinic and to continue contraceptive use.

Another area that is almost never mentioned and may turn out to be the most important one is condom distribution. I was talking to some people in a "good" foundation recently and was told that the board of that foundation would never give money for condom distribution. I asked, "Why not?", and was told, "We just can't go to the board and talk about condoms".

Yet there is very substantial evidence, (old evidence from the U.S. and more recent evidence from other countries) that pregnancy rates and sexually transmitted disease rates have been lowered where condom use is higher. You don't need a lot of research to tell you to get out in the streets and make condoms more available to young men. Studies show that they will definitely use them.

Some interesting new programs put together school remediation, summer employment, and life planning (a mix of vocational education and sex education). Preliminary data from Public/Private Ventures in five cities indicates lower truancy and increased attendance rates at experimental junior high schools. The life planning training produced higher knowlege levels about contraception among the treatment group.

Moving along into programs where there would not be direct access to contraception, we find a whole new field developing around life planning curricula, a mix of sex education and vocational education. What they clearly say is, "What do you want to be? If you want to be an architect, then you can't go off and have a baby because you have to get into the academic curriculum."

One example is "Choices," a program promulgated by The Girls Clubs of America. Using an attractive workbook, students make decisions about life choices, fill in family budgets and interview models and family members. The message is really strong, directing young people to become professionals and to delay having children until they are responsible adults.

Sex education, like other programs, is difficult to evaluate even when experimental and control groups are available. While the experiment is going on, other events are also taking place among the control group over which researchers have no control. In one extensive evaluation of programs for teen mothers, everybody was terribly disappointed because the intervention did not really reduce the long term (second year) repeat pregnancy rates. It turned out that the teen mothers in the control groups had access to all kinds of programs

in their communities. Thus the comparisons at the end of the two-year period revealed no significant differences between the experimental and the control groups.

Many kinds of peer counseling efforts have been organized such as teen theater groups, male outreach programs and clinic aides. Participants in teen theater groups and those who become counselors are greatly motivated by the experience but it is not clear what the communication really does for the target audience they are addressing.

Another group of programs is coming out of the area of prevention of substance abuse, based on improving decision-making skills, "resistance" therapy and other curricula. There is a small body of research that shows that young people can be taught to make decisions in a more rational way. One project has shown that the students that are in a skills-training program become better users of contraceptives when they became sexually active.

Finally, we get to traditional sexual education, which I should have started with because somewhere between forty and seventy percent — depending on which research you're reading — of all school children are now exposed to some form of sex education. There are great differences in the studies about whether it has an effect or doesn't have an effect; whether sex education increases or decreases sexual activity; whether adolescents use contraception better if they've had sex education; but, in general it is a wash. Everybody acknowledges that it is important, just like it is important to speak English. But if we use the same criteria as for literacy (e.g., most students in U.S. schools "take" English and about thirty percent are functionally illiterate) I would say sex education as it is generally taught probably has about the same effect.

Currently within the adolescent pregnancy field, largely with pressure from Washington, there is a movement to develop "saying no" programs. The model teaches students how to say "no" to somebody who asks them to have sex. That approach is being evaluated and there is no indication whether it will be successful. I am a bit skeptical about whether a brief course will have the desired effect. There are also many new programs in parent involvement. Many of these phrases like "say no", and "parent involvement" are very important buzz words, but I think they keep people from having to deal with the hard realities of pregnancy prevention. They may be important ideas, but the research on parent involvement programs shows that it makes no difference in pregnancy rates. This is partially because the children who are most at-risk have the least accessible parents and those parents want someone else to help their children because they really can't. In fact, a very high proportion of U.S. parents (85 percent) have said that they believe in sex education and they want the schools to offer it to their children. Surprisingly, more than two-thirds said that they want the schools to have birth-control clinics.

Reference was made to the Alan Guttmacher Institute study. The AGI study certainly offered the American people some sense of the need for creating a climate "in which teenagers could grow into responsible adults." I think that was the message and that message has been heard and is being acted on in many communities. What is happening today is all kinds of exciting community-

based collaborations, the embracing of the life-options approach, which brings together health services, youth services, social services and, most importantly schools. The whole question about schools resisting sex education is really no longer relevant. As it turns out now, there are already sixty multi-service clinics in sixty high schools and schools all over the country are competing to be allowed to work in collaborative pregnancy prevention programs with support from major foundations and state and local funds.

So, the number of the players has been expanded enormously and also the shape of the debate is really beginning to change, from sexuality to the quality of life. If we can really push that forward I think we will be making a great contribution to young people. What this implies is early intervention and many of us talk about as early as Head Start. It implies boys as well as girls. It also points out that if the research was complicated before, this makes it almost impossible.

I just want to add a personal end note to this which comes from my many years in studying teenage pregnancy. I personally think we don't need any more research on this issue. I think we know that bringing critical services to disadvantaged children is a good idea. I think you can do your own "interior" research and figure out why you "made it." How did you get in this room? Maybe you had somebody helping you to achieve in school, supporting you to go to college, to succeed in your career, and most importantly for this discussion, to control your fertility. In fact, when I was growing up, and probably when you were, it was *unthinkable* that one would become a teen mother or a teen father. I think from both the outer research and inner research, it should be clear that teenage pregnancy will go away only when the society decides, on a community-by-community basis, that it's *unthinkable* to allow children to become parents by default.

Jerome Goldsmith: Tom Berkshire is Assistant for Policy to Illinois Governor sames R. Thompson. He directed a federally funded study entitled *Preventing Teen Pregnancies: A Public Policy Guide.* He will discuss the government's role in prevention programs.

Implementing Programs

Tom Berkshire: I'm going to take somewhat of a different tack than Karen and Joy. My job with Governor Thompson is that of a program inventor. I'm not an expert nor do I concentrate on adolescent pregnancy. I spent most of last year working on agriculture policy, which is just fertility in another field. Nonetheless, my expertise is in putting together a program in a political context. Governor Thompson, as most of you know, is a moderate Republican who is currently running uncontested for the fourth time.

Let me get into the substance. We started in Illinois in developing an adolescent pregnancy program based on the fact that Illinois is the state that has the worst infant mortality rate for any industrial state. In looking at what one

might do about that, we identified the teen population as the group most at risk and the one most easily targeted. As we've advanced and developed into what has become the largest adolescent pregnancy program in the United States, we've come to realize some things that I think are interesting in this context. A large portion of the adolescent pregnancy problem, I think, is the creation of government and thus it seems appropriate that government become very involved in ameliorating that negative effect. Currently the major cost of adolescent pregnancy falls back to Government: the health costs, the costs related to children being born too soon, things like infant mortality, low birth weight, children leaving school too soon, long-term welfare dependency. It's important to note that lessening the impact of adolescent pregnancy on society will also lessen the size of government.

I think one of the other things that we have discovered is that until there is a long-term birth control pill or device which is being marketed, you really have to develop very complex programs in order to address this problem. Currently, most people are going away from, as Joy said, the chemical overlay as a single approach. It hasn't worked. It works if it is associated with other things, but as a single effort it really hasn't worked. Part of our attempt in developing a program called Parents Too Soon, in Illinois, was to develop those different kinds of programs, and as they evolve, those programs are becoming more complex.

We also continually stress in our work that most teenagers don't have children but most do engage in sexual activity. Teenage pregnancy in Illinois, and I think in most places, is not a random occurance. We can find target population groups and sub-population groups where teenage pregnancy occurs very frequently. We have developed a little model in one group where we believe we can actually identify the family in which a teenage pregnancy will occur perhaps even before the children become sexually active. We feel confident enough about that to discuss targeting prevention services to those families.

As a society, and this is where the media and the political context interact, we are constantly faced with a cultural denial of the sexual activity of teenagers. Everytime we start up a program — the one you may be familiar with is a school-based clinic we started up in Chicago — the media stories and, either following or at the same time, the political quotes fit very nicely into the realm of "they are not sexually active — this is trying to promote something that doesn't exist." The media for us, in terms of creating a program that will work, becomes part of the problem. So does the political context. We have to work with that, and we have to address that then as part of the solution.

Bringing the reality of what actually is happening in the world of the teenager into public awareness, and making it accepted, becomes very important in terms of resolving or managing this problem. We've tried a number of things in Illinois. We actually started the Parents Too Soon Program. This is $12 million effort. We have directly served, in the first year, over 45,000 teenagers and indirectly served, through either hotline or educational communication, a much larger number. Parents Too Soon started as a media program. Once a year the Illinois Broadcasting Association meets with the governor and the

governor says" I'd like you to do your public service announcements on whatever." This year it's employment. In 1983 we picked Parents Too Soon and announced the $12 million program. The idea was that the broadcasters would support the governor and use this as their selected PSA activity.

We spent $100,000 in developing advertising for that. We developed a whole theme. We developed a video rock song that addressed adolescent pregnancy. We had little clips, big clips, things from radio and TV, and then we had staff that urged radio and TV stations to use the PSA announcement continually.

The major message in that was a very moderate kind of message: "If you are a teen and you need or know somebody who needs help, call the hotline!" Then we also carried this out in goofy brochures that would be appealing to teenagers. I've never been able to read this but it's got all kinds of trivia in it. And then for us old fogies they did one which is the kind you'd read. The whole attempt was to stress: "If you need help, call the hotline." We could track where the advertisements appeared, and we could see the impact the media had on this problem. We knew that if an announcement appeared on Saturday during a baseball game on the Peoria station, we'd start getting calls on the hotline from Peoria. Anyway, that was our attempt to try to bring the media in on the problem. We just issued another $100,000 contract for the next phase of the campaign.

Parents Too Soon was primarily an activity designed to help stop repeat pregnancies. As you probably know, about thirty percent of all teenage pregnancies are repeat pregnancies. Twenty-four percent of that group were having their second child, six percent their third child, and it got to a point in 1984 where we actually had three precent where we were talking about their fifth child. Unless there are a lot of twins in that data, it's hard to see how that happens. We have 500 or so kids who are less than fifteen-years-old when they give birth for the first time, so I guess they have five years to pack in others.

But our attempt was, and again it's a moderate measure, to try to reduce repeat pregnancies. We could identify it; that's another way we could target. We knew who the children were once they were pregnant . Then we'd tried to get them so they wouldn't go back again to another pregnancy. To do that we used 126 different program contractors. We tried to use measures that we felt worked. We tried to direct money toward areas where we knew the problem existed and where there was high infant mortality, high teen pregnancy and, because we were crafting federal programs, where there was also high unemployment. The results looked pretty good for a year. We put alot of money in some of our programs. In one, in the southern seven counties of Illinois, we had absolutely no repeat pregnancies. I was telling this to somebody yesterday and he said: "Give them a little time... It's only been a year... Let them breathe for a while..." So, at the average that you find in the MDRC study and in some other ones, we should see something in the neighborhood of seventeen to twenty-two percent repeat pregnancies.

Another problem we are looking at is low birth weight, and again we had very good results in affecting the problem. Across the board in our program the low birth weight level was better than the state average. Then we had good results in terms of getting kids back to school or getting them to take the GED's (High

School Equivalency Exams).

We tried some other things that were either interesting or just fanciful. We worked with Control Data on a Parenting Program, an interactive computer program, where kids sit down and work through parenting problems with the computer. The kids like that very much because they see the experience on the computer as word processing experience. This quickly led the kids from Control Data's Parenting Program to taking the GED. It was a training program for high school skills. Kids could see the link and immediately knew they were gaining some skills. We have no way yet of knowing whether the parenting part works. We will have a way because the state has a central child abuse registry that allows us to match names and so forth. But at this point in time there is no way.

The Collaborative Approach

We also try to peddle our programs and worked in a collaborative effort with several other states to promote the use of Parents Too Soon. We had a small grant from the federal government to train other states in how to develop state-level policy for adolescent pregnancy. We brought seven states together and worked with consultants to develop a program in those particular states. Then teams of people from those states that are working in health, employment or other allied fields joined together to work in a collaborative peer group effort. We are selling this as a way of approaching the new Federalism. This is a classic instance of states-running-away-from-the-federal government. The federal government is decreasing the amount of available money. How do you run human services programs or other programs under Reagans's New Federalism or the Congress' New Federalism in terms of Gramm-Rudman? This discourages us from turning to the Feds. You turn to each other as a group with the states and work collaboratively. Look at the expertise. We had Florida, Mississippi, Colorado, Pennsylvania, New Mexico and Ohio working together — the best of their people — developing programs that fit their particular area. We've had very good success in terms of actually creating programs that way.

As I mentioned briefly, we have developed a predictive model for the Aid to Families with Dependent Children (AFDC) case load. We now need more money to actually implement a program that will allow us to identify those families with teens who are likely to become pregnant. What will you do about that? That requires building a program around case management that will try to keep the kids in school, try to get the kids lined up for summer jobs, give them access to health care, and so on down the line. In Illinois, and in many states like Illinois, such as New York and Pennsylvania, there is a huge number of services available, but getting the kids to them is the trick. If you've identified the kids, that's the direction you want to go. I think in terms of the Parents Too Soon Program, we are turning to the prevention in primary terms. We are in a position where the data on repeat pregnancy indicates we're doing the right things. The number of kids getting pregnant is going down. It's gone down between 1980 and 1985 over twenty percent. There's been an eight percent

population decrease in teens, so some of that is attributable just to the decline in population. Part of it then, you can say, is attributable or at least is influenced by the availability of services.

In your packet you see a book that was also developed from the Office of Human Development grant. It's 100 pages written at the level that governors can understand. It's very simple and says what is working and what we know about the problem. It tells them what they are able to do. We're trying to construct this program as something that even moderate governors around the country can implement to actually make an impact on the problem. I think the first things we have addressed are the repeat pregnancy issue, the health issues, and then when you feel more comfortable with these, the more primary prevention issues. That's the direction we've taken with Parents Too Soon in Illinois and we are trying promote it around the country as we proceed.

Jerome Goldsmith: Thank you very much Tom. Finally, Jerry Kitzi, executive director of Adolescent Resources Corporation, will speak of his experiences in running three school-based clinics in Kansas City, Missouri, and the results of a three-year study of that program.

Jerry Kitzi: I know what's on the agenda for me to speak about. Of course I too have an agenda. I hope that the Carnegie Foundation or one of the sponsors today will give me or my program a cash award for staying within the seven minute time allotment.
associated with teenage pregnancy. They're in the papers and have been referred to by my learned colleagues here. The one thing I regret is that I don't know how to convey to you the seriousness of the problem. I think that when you hear information about it and you read about it, it probably means the same to you as the nuclear disaster in Russia or toxic waste dumping in the U.S. If it happened to you personally in your family, then you know. Or if it happened to you personally as a teenager, then you know. Or if you worked in a clinic and you have seen an abused baby, then you know. So don't take these statistics lightly. This is very serious.

School-Based Clinics: A Marketing Approach

School-based clinics I can sum-up in about two minutes. They're nothing more than a marketing approach to health care, to an otherwise non-user population. These school-based clinics are comprehensive in nature. I don't think you'll go to any program anywhere in the sixty clinics that Joy referred to and find just a teenage pregnancy program — unless you're reading the paper. Most media people refer to these as family planning clinics, which is unfortunate because they're not. They are comprehensive programs.

The average for any of the sixty programs might be that fifteen to twenty percent of the services are related to OB-GYN. So they really are more comprehensive than the media makes them out to be.

You don't even have to offer family planning services in these clinics to affect teenage pregnancy. With one of the first clinics we opened, the community decided that we would not have family planning education, counseling, or medical services that first year and yet we prevented pregnancy. You can do that with a nutritionist who works with young people about body image. You can do that with a dentist who might be able to help a young person with their smile to feel good about themselves and improve their self image. You can do that with a social worker who will listen, or even a dermatologist. They do more to prevent teenage pregnancy than anybody.

The bottom line is that kids don't feel good about themselves, especially in certain target populations that Tom referred to as lower social economic groups, who have no sense of the future. That's really unfortunate. So they do something that's temporary for them and that means starting a family. There are many other ways of making an impact with these clinics, not just in a family planning service. Obviously it's very important.

I won't read to you what's in your packet, but we did a three-year study in Kansas City. I think anyone who tries to report on rates of pregnancy has a very difficult task, as Joy mentioned. It's so hard to document. We are able to document a little bit about rates of live birth. Just as in the St. Paul and Baltimore clinics we are able to document a little bit about the use of contraceptives in continuation. I'm personally happy as a program person to see that many of the changes occured with males because many of programs do just address females. We had a change in behavior among males who never use contraceptives from forty-five percent of the sexually active population now reduced to twenty-six percent.

The other aspect of the clinics that Joy mentioned was education. It's refreshing for me to know that when we started the programs twenty-six percent of the kids who are sexually active had no idea whether they were using a method of contraception. I find that very hard to understand, but at least that's down now to ten percent. So we're having some impact in education as well. But I don't know what's going on with those ten percent. They're not sure or they don't know.

That's really not the issue again, it's just the marketing approach. We took away the barriers to health care. We have an impact on suicide and we have an impact on kids who have never seen a doctor or who have not seen a doctor in the last five years. We have taken the barriers away and created easy access. I think that was mentioned a few times. That is all school-based clinics are —easy access. They are not by any means the answer to teenage pregnancy problems. You've heard about a number of programs over the last hour. They're all fine, but as I look at the clinic itself, it's a practical approach, a band-aid approach. It's not really dealing with the root of the problem. It's dealing with a problem as it exists right now.

I see you playing a different role rather than just gaining information from us. I'd like to see the media as the catalysts to the answer to the problem, and the answer to the problem lies with the family and church. I'd like to be pro-family but most of the issues around pro-family are only revolving around

whether or not a person has an abortion anymore. Pro-family goes so much more past those issues. I see that young kids have no existence with family as they get older and enter into their adolescent years. I think the most alarming statistics that I've read were in a book by Steven Glenn on strengthening the family. He cited a study done by the Pacific Institute that measured interaction between children and family. I think the data, if I can report it correctly, indicates that the average teenager today spends fourteen-and-one-half minutes each day interacting with an adult family member. Twelve minutes of that is negative. "Why is your hair purple? Why do you wear so many earrings? Why do you wear so much make up? " And those are the boys we are talking about. So the problem is that there is a lack of interaction within family. And therein lies the root of the teenage pregnancy problem or, as Joy will find out if she goes into the drug and alcohol area, that's where the root of the problem is for drugs and alcohol.

There was something else that I heard you remark about and it has to do with environmental impact on these kids. The breakdown in the family certainly is to me the crux of the whole problem. Nevertheless, consider the impact of media like HBO, SHOWTIME, MTV. No matter how much sexual innuendo there is in their broadcasts, no one's rushing those channels or those programs off the air. Yet they do have an impact. Madison Avenue and advertising certainly is giving a clear message to young people "Look sensual, be sensual." That has a tremendous impact on the way kids are thinking today. But I don't see anyone marching down Madison Avenue kicking advertising people in the butt and saying, "Stop this."

The only real answer seems to be that we have to get to the parents of these young people and say, "Gee, I know you wanted a family and aren't you happy, but now that the baby's no longer a baby and and it's three, four, five years of age, why are you giving up on this kid now, and thinking I want another young, little cuddly thing?" That's the way these young people are thinking. They want something young and cuddly that is totally dependent. Once a kid starts thinking, then they start giving up on them.

So my request of today is that you put the blame where the blame belongs. The blame doesn't belong on sex education and family planning programs. They were created to address the problem. The blame falls on parents, but nobody is shaking a finger at them because that might not be right. But that's where it is.

I haven't spoken at all about school-based clinics because you know all about them. But if you want to ask any questions I will talk about them. Thank you.

Questioning the Experts

Jerome Goldsmith: Thank you very much. Let me introduce Ed Pitt. He's going to participate in the question and answer session. Ed Pitt is Director of the Health Cluster of the National Urban League, which includes coordination of the Adolescent Pregnancy Prevention Program with special emphasis on

male responsibility. Thanks for joining us, Ed. Now we'd like to answer your questions.

Question: I'd like to know where the sixty clinics that have opened are? Is there a regional trend and is there resistance in the conservative areas in the country?

Jerry Kitzi: The clinics have developed in communities that want to do something about the problem of teenage pregnancy. There's no set pattern of our government agency or foundation saying we are going to place them here, here, and here. They seem to come from a gathering of people within a community who are tired of this problem and want to solve it. They come together and say, "Let's look at all the options, since school based clinics are attractive right now and seemingly effective." It just develops kind of like that, but there really is no such pattern.

Question: I'd like to know where the clinics are. I understand some of the motivation, but...

Joy Dryfoos: They are all over, they're random. Most of them are in rural areas, New Mexico, Arizona, ...Mississippi has a model. They're really all over and they certainly are in very conservative areas.

Tom Berkshire: Except for Minnesota, I think that most of them started in the South, no? Didn't they?

Joy Dryfoos: Jackson, Dallas, Houston, Kansas City...

Jerry Kitzi: As with all trends it started in the Midwest and went to the coasts.

Joy Dryfoos: That's what happened...That's exactly what happened...There are lots in Michigan.

Karen Pittman: There's a somewhat now outdated list in the article on school-based clinics and that's in the packet.

Question: I was just wondering. People didn't talk too much about reasons for pregnancy but the feeling I got — it was sort of implied —that it is deliberate often because these people have no other options, no other alternatives. I was wondering if someone would address the idea that teen pregnancies are not necessarily deliberate, but rather a refusal to acknowledge sexuality. It's the kind of idea that if you use contraceptives that means it's a premeditated act.

Karen Pittman: I think that's very important. People often begin by asking, "Why do we have this problem? Why do we have so many teen parents?" I don't think the reasons have changed very much over the past twenty, thirty or forty years. By and large, we end up with teen parents because there is an unintended pregnancy. And the estimates are that about eighty percent of teen pregnan-

cies are unintended. And you need to put that into perspective. About fifty percent of the pregnancies to all American women are unintended. None of us are doing a very good job of planning this.

Teenagers are a little bit worse than we are at planning, but not as much as you would think. It's not that you somehow hit that magic age of twenty and you're absolutely in complete control of reproduction. That's not the case at all. But I think that the rate of unintended pregnancy is up because sexual activity is increasing. Even though contraceptive use has increased it hasn't kept pace with sexual activity. People often ask, "Why do teenagers have babies?" They have babies for the exact same reasons that all of us do. There is a very strong and reasonable tendency for people to want to be parents or we wouldn't continue to recreate ourselves. So it's more a question of timing and it's more a question of being able to weigh decisions. We do have a lot of unintended pregnancies. One thing that has changed is the separation of the event of unintended pregnancy with the event of marriage. Those are now more separate decisions than they used to be. The first doesn't automatically trigger the second. Again, we haven't measured it accurately to income but it's true for white teens and it's true for black teens. That decision is no longer as neatly coupled as it used to be.

But it is also clear that one of the reasons we have high numbers of unintended pregnancies is because of that delay between becoming sexually active and deciding to get contraceptive information and to use it. There probably are lots of reasons for that which people list off — the ignorance, the normal myths of "I can't get pregnant, I'm too young, I can't get pregnant the first time," all sorts of things. A large element of it is the ambiguity in many people's minds. "If I go out and get contraception, then I'm planning to be sexually active." The best thing I can do with mixed messages that are coming in like parents and adults saying "good girls don't" — and it's mainly "good girls" — is reconcile the fact that I am a good girl by continuing to think I am because sex is spontaneous, it's romantic, and I'm not planning on doing it. That certainly is a part of it.

But I think, as Jerry said, we must be able to bridge that gap by getting adults to talk, providing services where kids are, and letting them understand that it's okay to come in and talk about it. I mean kids don't come in and talk to their parents about it. They talk to their parents about it and then it confuses everyone else and then they turn on the television and it's a lost cause. So in many ways just having adults available — whether in school-based clinics, youth-serving agencies, or churches — who have identified themselves and are not judgmental, goes a long way toward being able to help kids and shorten that gap between becoming sexually active, being able to acknowledge it, and being responsible about it.

Jerry Kitzi: Can I just add one more thing to that? There's something very critical though. We can make a great impact through education and services on that kind of person that you're talking about. But when kids under seventeen come in for a pregnancy test and are disappointed when the test is negative . . . That's the group we need to refer to and look at. We have a group that

provides pregnancy tests to girls seventeen and younger. We average about fifty negative tests a month. Yet only around two percent of those people are willing to go to a family planning program. What's happening to cause that?

Joy Dryfoos: One thing to watch for in the research is better documentation that a certain portion of teen pregnancy takes place following involuntary sex. The figures are astounding. Some of the studies in fact that are going on in Illinois are surveying teen mothers to find out what proportion of them have ever experienced sexual abuse, and it's somewhere between twenty-five and forty percent. In my own estimate that means around ten percent of teenagers who become pregnant did not consent to the act, whether it was sexual abuse or whether they did not quite know what was going on.

Tom Berkshire: If I can add just one thing that's a little, I guess, starker. In Illinois fifty-three percent of all the children born to AFDC mothers were born to teen mothers. Now I mean that doesn't sound like happenstance. It doesn't sound like "I didn't want to. . . I didn't care." It sounds like we have a cultural thing in certain families where teen parenthood exists and which are more likely to have future teen mothers and fathers in them. I think that's not mystical, that's just one on one. If we can just identify those families. . .

Karen Pittman: I think that figure of somewhere between fifty and sixty percent of women who are currently on AFDC rosters being teen parents has been around for a while and documented by enough different people that we can accept it. I am going to make an exception to what you are saying is a cultural phenomenon, however. I think we are clearly seeing an economic phenomenon. You have the same thing happening when you try to ask about the kids of single-parent families. You start acquiring all kinds of devastating research about kids in single-parent families.

Behind this subset of single-parent families that we're talking about, I think you have to look at the economics of it. In the general research of single-parent families, when you control for income and for the fact that single-parent familes are very much likely to end up poor and for longer periods of time, many negative things that we want to talk about tend to fall off.

I don't know that there's something cultural and intrinsic about having a mother who bore her first children as a teenager, except that it seems to relate to a whole host of variables — of lower education, of lower work scales leading to lower employability, leading to less of a career income path that is going to move you out of poverty. Then poverty itself puts you in a lot of circumstances that are then going to affect your child in a way that that kid, independent of what you can do for him or for her, is going to be at a disadvantage. He or she is going to be in a neighborhood where there are fewer role models, where there are fewer people going to work everyday to look at, where there are lousy schools, where there are fewer things to do when you come home from school. I think that we have to keep it in that perspective. That's not to say that if we had perfectly wonderful data and we could control everything, the problem would

go away and we would see zero effects. But I'm sure that they would drop significantly enough so that I don't like to begin the discussion by saying that what we're seeing is a cultural problem.

Ed Pitt: I'd like to reinforce that position. I think the only cultural way in which we can begin to view this is as the culture of poverty. There is a tendency now —and it's very discouraging to me and to the Urban League — for people who are in the provision of state-funded and federally-funded initiatives, as well as those in the media, to begin to identify teen pregnancy as a phenomenon and a very individualistic phenomenon. The tendency is to redirect the thinking toward individual inadequacies and begin to come up with penalties. We are very concerned now that some very negative ends are being sought. The media is now being introduced to solutions and theories that will have us condemning indivdiuals when we are really addressing situations that are so phenomenalistic, that are really so broad in their dimensions, that one cannot even begin to talk about them as individuals. It really does reflect the conditions, the life options, the quality of life, the poverty, the impoverished state that people are dwelling in. When we begin to focus away from that individual phenomenon and begin to look to programs — teenage pregnancy programs —and ask them to solve the problem of teenage pregnancy without finding the larger issues of poverty and the life conditions that people are addressing themselves in, we have really begun to put the blame in the wrong place.

Parent Child Roles

Question: I want to ask Jerry if we're going to back-track all the way to the bottom line as you mentioned it. What does the research show about what parents can do? Do we need to go all the way back? The nature of teenagers' lives these days is such that my daughter is home maybe fifteen minutes a day. They are busy. If things are going well for them, they have active lives outside the home. They have interaction away from the home a great deal. If you're going to make the home atmosphere as supportive as possible, how can our children make it comfortable for us to talk to them as much as possible, even though they need to seek . . . you know I agree that they definitly need to seek this... adults who are not their parents?

Jerry Kitzi: Well, in areas of family, I would refer you again to Steven Glenn's work, the one where he made the strongest plan of action for parents. It is the one entitled, "Strengthening The Family". It suggests letting kids know, from a very early age, that they can make some decisions and we can help them to do that possibly by including them in family activities. When a teenager becomes fifteen, and she's only home fifteen minutes a day, if the other twenty-three hours and twenty-five minutes are not wasted time, it is important to use that time to say, "You are somebody and you can achieve." That's positive then, at least. Hopefully the fifteen minutes she's home is all spent with you. There needs to be some sense of achievement.

Question: I'm wondering what advice is being given because there was a mention —I don't recall if it was you who said it — of "the cradle-to-grave approach."

Jerome Goldsmith: I think the work that's done in family life education really tries to focus on that issue. There should be an effort to at least eat with your children, they do at least have to eat once in a while...

Question: No, what I'm asking for are very positive and specific examples. If you are going to say, "OK parents," as we usually hear, "it's all your fault." I think it's important to give parents and particularly the parents of kids who are at most risk — for instance those parents who may be working two or three jobs, and may be outside of the home a tremendous amount of time — some of very positive and specific advice.

Joy Dryfoos: There is research which shows, it's so obvious really, that parents who communicate with their children find their children make decisions better and are better contraceptive users. But again it's very much what I would call class/middle-class kind of research, and when you go into schools which are now the surrogate parents of the children they will tell you right up front that it is very difficult. The parents are very burdened by trying to make a living. There are many single parents and people working two jobs. You cannot get them to come to a school or go to a church and take a parent training program like other parents may do. So although we can say all this, I think that all of us have conveyed a little skeptisism about that as a very viable approach. We all have to say it. We must involve parents, but I think none of us here would say there are any terrific examples where this has been very successful.

Tom Berkshire: When we were trying to create the Parents Too Soon Program, our initial effort was to try to do it around the family, which is becoming a very politically popular thing to do. And it really isn't, the evidence is so skewed. We really couldn't say, "If you structure your family interaction this way, you can expect positive results." You know, hopefully, that's right. It makes sense.

Ed Pitt: To maintain that a sixteen-year-old parent is immature and the decision of the parent is immature in the first place, to assume that that parent is going to give mature advice, to assume that a person is existing in a very intensely impoverished state and is going to have the clarity of mind and so forth to take on what you call "normal" counseling, involved kinds of decision-making, is a value judgment that's being imposed without some sensitivity to the conditions that people are living in.

We are saying, "Why can't poor, impoverished people behave like middle class people? Why can't you tell these guys to stop making babies unless they are going to take care of them?" As far as the National Urban League and other organizations are concerned, we stress male responsibility by getting some message out so that these guys will stop making these babies. Unless they are going to take care of their babies, they are costing the government money. Yet the government does not want to go out and identify some of these guys

because to identify them might mean that that they will have to give them a job, or put them in jail to carry out what they call regular responsible male behavior or parental behavior. To do that would cost more than to ignore them. So a lot of males are just ignored. A lot of parents are just ignored. Male parents are just ignored. Their responsibilities are not really a major concern.

But the rhetoric of it is very popular now. For instance, "Be Responsible, Be Careful" is the theme of the National Urban League's campaign for males. "Don't make the baby if you can't be a father." Yet in Atlanta, Georgia, a few months ago, so much pressure was brought on a pharmaceutical company that was trying to put billboards up advertising condoms that on the first day they had to take all the ones down that they had put up. Local TV stations did a survey of the community to find out their attitudes on condoms and the advertising of condoms. The public was evenly divided fifty-fifty on that survey, against just putting up a billboard on contraceptives, a regular condom ad. The interesting thing, and very disturbing, was that women overwhelmingly were opposed to putting the ad up. Males were more in favor of it.

So this whole schizophrenic notion about sex education, about male responsibility, the whole thing about prevention, how one goes about preventing pregnancy, what we do, what we tell people, what we expect from them, and how we intend to support them in their decision-making process, is so rift with conflict. I don't think that we even feel that comfortable among ourselves, about what we want to say, how we want to say it, and what we expect in return for it.

Physicians' Responsibility

Question: You've addressed the responsibilities of schools and parents. I'm wondering if there is a role here for physicians?

Karen Pittman: There is a very important role for physicians and some people are attempting to move them along in that direction. I'll just give you a couple of examples. First I want to emphasize that there are some basic roles. There is a role for physicians to be a part of the health system that's taking care of these kids. If we're talking about kids that Jerry Kitzi sees in his clinic, they did not have regular visits to private physicians before the clinic came along. So whatever we do to move the medical community along as far as private practice goes is not going to have an impact on those kids. I mean adolescent medicine for a lot of people is sort of a no man's land. Pediatricians don't want to deal with them once they get to that age and they're not quite old enough or feel comfortable enough to go to a regular general practitioner. They are left in the waiting room with their little lambs behind them waiting for their appointment. People are recognizing that now and making efforts to move physicians to be more comfortable to include in their protocol when they are talking to teens, the kinds of questions that we're addressing. Not just about sexual activity but drug and alcohol abuse, suicide, depression and stress. They must expand the protocol beyond, "When was your last cold and let's weigh you!"

There is one piece that I think is very exciting, and I just received a demonstration of it last week. There is a doctor in Hawaii who through Kaiser Permanete developed computer-assisted medical protocol. They have it in all the medical clinics in Hawaii and they have it in about a half a dozen schools. Rather than coming in and having that uncomfortable question and answer period with a physician, the kid sits down at a cheap Radio Shack computer and it says "Hi, Lisa, how are you?" You type in your name and then go through a fifteen-minute protocol asking all the sensitive questions. This leaves the doctor to do height and weight and you know, "when did you have your last cold?" What they found was that they had an enormous increase in the number of problem areas that were reported, from sexual activity to sexual abuse, to suicidal tendencies, to alcohol abuse. Things that kids were not willing or comfortable to say face to face with a physician or even a written questionnaire they somehow were able to entrust to the computer. There is something magical about computers and kids, and they were somehow able to trust computers.

There are also some studies coming out about another Kaiser Permanente project. They are doing something to help physicians expand the protocol and include these things in providing backups so that physicians feel more comfortable once the issue surfaces and are better able to deal with it. We also have just basic problems on the other end of getting OB-GYN people to take in low-income women, teens or otherwise, for prenatal care. We have problems in getting hospitals to take low-income women for delivery. So it's not uncommon to have someone waiting outside in the parking lot until the delivery gets to an emergency situation so that they can go into the emergency room, which has to admit them. So we have more than just the thirteen-year-old sitting in the pediatrician's office feeling uncomfortable. We have some basic medical problems that have to be addressed. On the prevention end, things are happening but as I said, one of the main problems is that adolescents are very much underserved medically, and that's the crucial issue that has to be addressed.

Jerome Goldsmith: I just would like to add from my own experience that I work with many hospitals, doctors, Health Maintenance Organizations, insurance companies, and what have you. Largely it's a function of time. You can't make money. You have to move very quickly. Adolescents take a lot of time whether people like it or not. These doctors are not really going to spend the time if it's not economically profitable. They may have the best intentions in the world. They just can't do it unless we work out another system that enables them to afford the liberty to spend time. They're not getting the information in their medical education either.

Joy Dryfoos: I just wanted to introduce some statistics here because doctors are very involved with teenagers and contraception. Of the five million girls or young women who are sexually active under the age of twenty, I mentioned that about a million-and-a-half go to family planning clinics. Well, approximately the same number, about a million-and-a-half, go to private doctors. So if you do your arithmetic, you will discover that leaves two million who don't go to

anybody and those are the two million whose problems we're really addressing up here.

Question: I am mindful of the fact by the questions being raised in the family research I've done for articles I've written, that the peer group is the most important group affecting young people. They put on the pressure to perform and to have that sexual debut. So many kids you speak to say, "My friends kept asking, 'Didn't you do it yet?'" And I think they turn to the peer group a lot. I know they do. My question is, although this forum has more to do with prevention of teen pregnancy, do all of you who deal with teens and with the repeat pregnancy situations hold out to them the possibility of adoption as a choice for someone who is too young to take on the responsibility of parenthood? I ask that question because I also know that ninty-six percent of young women who choose to have their babies also choose to keep them, and I'm concerned about that statistic.

Tom Berkshire: Concerning your first point, about $3 million or $12 million is spent on peer group activity. There is a peer group called The Minnesota Early Learning Development Program that has been converted into MELD for young mothers. This is a group where we actually pay teen mothers to lead groups — I guess you'd say previous teen mothers — and share with pregnant teen mothers the experiences that should help them be able to contend with their pregnancy and their child better and to help them work on the repeat pregnancy problem. Because we operate in the political context all the alternatives are explored.

Question: Including adoption?

Tom Berkshire: Oh, absolutely, absolutely, and those programs are run by our Department of Children and Family Services, which is the agency that controls and operates the adoption program for the state. So it's part of their ethos. That's really never been that much of an issue. I don't know about the other programs.

Jerome Goldsmith: I'd just like to say that adoption is almost always offered. The problem with adoption is that the decision is almost always regretted by the youngster. Because of the age at which they have to engage in adoption, the long-range psychological impact is frequently one of regret and remorse and the period of adoption doesn't allow for a period of mourning. It's like a death to a youngster, and all of that has to be taken into consideration. We don't do as well at it as we should.

School Drop-out Complications

Question: Is there any existing legislation or effort to create legislation that would compel local school districts to report and keep track of pregnancies in the local school system? And the second question is, do we find that a number

of teens who get pregnant have to drop out of school because they can't find anyone to care for the infant — whether it's because their parents or grandparents refuse to or can't or because the costs of private daycare services are prohibitive? We find that some school systems are experimenting with setting up infant daycare facilities on school sites and I'm wondering if this is beginning to be a trend around the rest of the country.

Jerry Kitzi: On question number one, I don't know.

Panel: The answer to number one is absolutely no.

Jerry Kitzi: Question number two. . . There is a trend, I think, towards providing daycare but there are two things to look at. First, in terms of bringing these young people back so they can finish school, we have a program in Kansas City like that, a daycare center within the high school — not within the schools that are also housing school-based clinics, but in a separate school — with the intention of providing it as a parenting lab for all the other students so that there is the observation, not hands-on, but observation of different parenting techniques. There hasn't been any data that I'm aware of published about the effectiveness over a three-or-four-year period of time with the mothers and their infants, but I think it's amazing. The teenage parent center that we have is doing fantastic work. Some of the kids are afraid to touch babies, and yet who is born with parenting skills? No one. So to learn them in an environment like that, through a theory class and a practical lab approach with observation, I think it's catching on. That concept is spreading. I know the Johnson Foundation just announced a new grant application for school-based clinics and for the development of that kind of model parenting education or daycare center approach as well.

Joy Dryfoos: There are very good models connected with school-based clinics; one in Jackson, Mississippi, another in Houston, Texas. I think about five of the school-based clinics have child care. It's very expensive. Everybody would love to do it, but the problem is to find the funding for it.

Jerry Kitzi: The problem is the liability.

Tom Berkshire: Well that's the whole point. The daycare industry has locked out our infants. Daycare is regulated to the point that you almost need a nurse for every two infants in some states. It's ok once they hit the age of three or four, when they're toddlers or when they're toilet trained and all that sort of thing. But that's not the population that we're addressing. We basically gave them a blank check for this population group. In two years or a year-and-a-half, they came up with 245 slots while you have 25,000 pregnancies a year. But the problem is that, as they said, it's so expensive because of the regulatory activity that the worst happens. If you want the kid to go back to school, then you leave him at an unregulated point and there is no middle ground that I know of that anybody has found.

Jerome Goldsmith: We're just giving up an infant care center at Ninety-Second Street in Manhattan because the cost of caring for those infants is $25,000 a year for day treatment and there is nobody in public service who wants to provide that money.

One wonders why it's so expensive. It's because of all the remarks made here about low birth weight and the kinds of children who need all kinds of specialized help. If you're going to provide those —unless you link it to a hospital where that kind of help is available — if you're isolated away from the hospital, then you've got to pay for it. It's the most expensive kind of care we've got and we're abandoning it — service for some forty-odd youngsters.

The Role of Religion

Question: What do you see as the role, if any, of organized religion? Are religious groups cooperating in any of these programs for example? Are there statistics on sexual activity and pregnancy by religious affiliation? Is there counseling for Catholic teenagers who may be pregnant? Where does religion fit into all of this?

Karen Pittman: I think religion fits in from a variety of perspectives. It fits in and plays a big picture primarily, at least from my perspective, because the churches, like the schools and the youth-serving agencies, are the central organizations that see kids, have kids and have provided traditionally private programs that serve people. So that is one place where we can get to the kids, get a configuration of kids, and get services in to them. I think that the various denominations bridge the spectrum, as you would expect, as far as to what extent they are doing things that are directly sexuality specific. At the Children's Defense Fund, we have just hired someone to actually be a full-time liaison person with churches, primarily at the national level, and we're going to be hiring a second person to work at a local level. But there are a variety of things that are happening with churches. I mean churches have a difficult problem addressing this issue, as anybody does, if not more so, because they go down on paper as far as what they are saying about premarital sex. But the Lutheran Church is one that has particularly been moving along and developing family sexuality programs, parent-child retreats, seminars, and classes. There are several black denominations that have been working actively on it. Catholic schools, for example, do go a long way as far as providing good sex education in these schools and see that as a responsibility, sometimes more than the public schools do. So the churches certainly are an important piece of this and a lot of them at this point are either doing things or grappling with how they can work with kids on the issue.

Joy Dryfoos: I think the key issue of the churches is that they are not rejecting these children. They have turned around over the last decade and have become as significant a part of this process as any of us.

There is a very high correlation between being religious and not being a teen parent. Religiousness is related to how frequently one attends religious services. There is, however, no correlation between what religious group people belong to and teen pregnancies. For example, there are virtually no differences anymore between Catholics and non-Catholics in the general public about almost anything: contraception, abortion, teen pregnancy, and all these other things. It really matters how often a person participated, whatever his or her religious preference may be.

Ed Pitt: Churches are very critical. We find that in dealing with males, churches have historically focused a lot of wrath, concern and criticism on the female. We find they've been reluctant to address males and male behavior and this whole notion of parenting responsibility. So we are very much becoming involved with churches around the issue of young boys, male behavior and male responsibility. We find that the church is very receptive to it. Large denominations in the black community now are becoming very, very active in this area.

Tom Berkshire: We funded a program called Octopus which designed a reference manual for churches concerning the adolescent-parent relationship. When we were doing that, we discovered that there are in almost every religion many ad hoc activities going on in the United States. The impact of it we don't know, but it's an accepted thing that on an ad hoc basis churches seem to be willing to do.

Question: I'd like to know whether any of the panelists have heard of any interest in providing tangible incentives for adolescents to delay parenthood and/or complete high school. By tangible incentives I mean things like a monetary award or a guaranteed college education or a job?

Karen Pittman: I haven't heard of any federal or state level proposals but there are certainly examples of that. One that has gotten the most publicity is right here in New York City. The Urban Institute has suggested that one of the things we can do is offer $2,000 dollars to anyone who makes it to age nineteen without becoming pregnant, but. . .

Joy Dryfoos: That's a good way to finance abortions. . .

Karen Pittman: Yes, but nobody's followed up on it to my knowledge. As far as completing school goes, you do see more of it. There is a dramatic example of this. I believe his name is Lang, a man here in the city, who seems to have sparked many of those kids to do a lot. There are programs that are linking summer jobs with staying in school and maintaining certain standards on how well you do. Then you can have a summer job, and if you do well again, you can have another. I think there are even simpler things that have been tried. There is a principal in one of the Washington, D.C., schools, for example, well there might have been a little money involved here, who required that all of his seniors fill out college applications.

He found that he was able to double the number of kids that went on to college just by making that suggestion. I'm not sure how the money was provided for the application fee. I belive that it's in Dade County, Florida, where they have decided to pay for the SAT exams for all juniors just in case there is somebody out there who wanted to take the exam but couldn't afford to take it. I heard — don't quote me because I'm not sure where I heard it — but I heard statistics about a week ago that in Cleveland out of the nine thousand seniors, only two hundred had taken the SAT test. I've heard about equally big gaps in Mississippi and other states. So I think that there are dramatic examples but there are also very simple examples of the kinds of things that we can do to help kids stay in school and help kids make the transition from school to post-secondary education.

Future Directions

Question: I'm curious to get a sense from the panel of how hopeful you are that society is going to begin to address these issues. I see trends that perhaps are leading us in other directions. I wonder how often you feel like you are a voice shouting into the dark with your concerns about kids. It seems to me that we make something of a commitment to increase our military expenditures, etc. I would tie into that a growth toward fundamentalism in this country which may also argue against community-based action on these kinds of issues, arguing instead that these are the kinds of things that kids shouldn't be learning about from other people. So I would like to get your sense of where we are going in this society, whether you're hopeful about the future.

Ed Pitt: The question you raised really ties in with the question someone else just raised. Where we are going as a country and what commitment that country has toward dealing with the problem of teenage pregnancy, I think, can be linked to the kinds of programs and responses that the country is prepared to put in place. Is the country prepared to deal with the problem of long-term unemployment in minority communities in this country? Because if it's not, it's going to continue to have a big problem with poverty, and as long as you have poverty as a condition in this country, you're going to have a number of other effects. You aren't going to be able to address, in my opinion, these effects by individualizing, by trying to deal with individuals who become drug addicts or individuals who parent too soon. The notion that there will be guaranteed jobs for high school graduates is a program that would encourage high school completion in this country. It would certainly represent a viable option to dropping out and to premature involvement in a lot of self-destructive behavior that ends up costing the individual and society dearly. The whole notion of being able to guarantee the next level of development in any sense, the whole movement toward being able to go as far as one's abilities will take them, including college education and other incentives to go further in life, will have a direct impact on the problem of teenage pregnancy in this country. To the extent that they are not adressed, we will be dealing with damage control. We will be trying to keep the numbers down as low as we can

and trying to find innovative strategies to reduce minimally, on an annual basis, that percentage of people who become pregnant. We will not be really addressing the conditions in which the problems exist.

Joy Dryfoos: Some of the loss in funding of human services is beginning to have its impact upon the service system. I think we are developing in this country a strong underclass — an underclass that will become increasingly a problem as it becomes aware that it's an underclass. On the other hand we are a very contradictary country. Some things are absolutely wonderful, such as the incredible advances that are made in our educational system. I think you are going to have both happen simultaneously. You are going to have a bi-polar country with those who have and those who have not. That, I think, is the danger.

Jerry Kitzi: I'd like to comment on that. I feel obviously pretty optimistic especially about Kansas City, since that's where I'm from. So I'll only speak of that microcosm of a larger society. The fact that there are community-based programs is so important. We saw in some of the studies we did changes in pregnancy and drug abuse, suicide, all those things. The job rates for those kids, because we instituted a job program or a referral service for summer jobs, grew from one-fifth of the population having some kind of part-time job to one-third. Jobs make all the difference in the world. You can prevent pregnancy with a job. So, it's critical that the community, unless it just doesn't want to address these issues, addresses an overall larger scheme. Believe me, we wouldn't be here if we weren't optimistic about a change.

Joy Dryfoos: I vacillate from minute to minute about whether I'm optimistic or pessimistic. It depends on, I guess, where I was last. But I have observed this phenomenon that I will call "hard times bringing collaboration." People are really beginning to work together who never did before. I would say I'm optimistic to the degree that I see there is now a recognition of the links between reproductive health care, education, unemployment, minority status and the groups that work with those issues. I think whether or not they can turn that into effective advocacy and become more of a political force than they are right now depends on how united they can be.

Tom Berkshire: The only other thing that I would add is that there has been a tremendous activity at the governors' levels and the state levels in this adolescent pregnancy area both in the legislature and the governors' offices. Probably about half of the states in the country have something on the front burner in that area. States have been going through a tremendous change in the so-called education reform area. Lots of states have been moving toward making Head Start education more universal. There's a link there in what we've been talking about. Lots of states in their educational reform have been working with dropout prevention and putting more resources into that. Again, there is the link. A lot of them like Mississippi have re-tooled vocational education and again, that's a link. So educational reform is happening across the states, and I think it is a very positive thing. I think that this is one area where you see the

shift from the idea that it is a federal area of responsibility to where the states are saying: "Hey, we'll take on this one." It's pretty optimistic from that standpoint.

Jerome Goldsmith: I think we have not exhausted the subject, but I do want to thank all the speakers on your behalf and I want to thank you for your questions. If you want to talk with these people privately, they are going to be here and will answer any of your questions individually. If you do need any further information or want to reach other experts, you can call the Media Resource Service at 212-661-9110 or at 800-223-1730. The Media Resource Service is available to you. Again, we thank you for coming.

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